

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST MARGARET HEALTH - DYER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>24 JOLIET ST</b> <b>DYER, IN 46311</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00176983</p> <p>Substantiated: No deficiencies related to the allegations are cited.</p> <p>Date: 7/23/15</p> <p>Facility Number: 005080</p> <p>Franciscan St. Margaret Health - Dyer is in compliance with 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.6-9, Other services, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 08/07/15</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE